Reference Number 200-09-DD

Title of Document: Fees for Residential Services Provided by the South Carolina Department of Mental Retardation

Date of Issue: December 1, 1990
Effective Date: December 1, 1990
Last Review Date: April 1, 1992 **REVISED**
Date of Last Revision: April 1, 1992

Applicability: Regional Facilities and Management Contract Providers

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I. SCOPE OF DIRECTIVE

The department's authority for charging for its services is established by Section 44-20-350 of the 1976 South Carolina Code of Laws, as amended; by Medicaid regulations governing amounts to be paid by Medicaid recipients for services; and by Commission Policy.

This directive addresses only fees to be charged for residential services provided to an individual within one of the department's four regional centers, and fees to be charged for residential services provided to an individual in a community-based habilitation facility under a management contract between SCDMR and a county mental retardation board or other community provider.

Fees for departmental services other than residential services are addressed in other departmental directives.

II. SCOPE OF FEES

Residential services shall include room and board and all support services and programs provided as part of the Habilitation Facility (ICF/MR) program, except certain medical services required for the health of the individual or for the medical determination of eligibility for the Habilitation Facility program.

The fee for residential services shall be a daily fee. The amount of the daily fee shall be the per diem payment rate currently approved in the Medicaid contract with the State Health and Human Services Finance Commission (HHSFC). The SCDMR Finance Manual, Section 6.1, lists current fees.

Application of the daily fee will vary depending on the payer being billed. Sections IV, V, and VI describe the various procedures.

III. PAYERS

Residential services shall be billed in the following priority order: first to trusts and third party insurance; then to individuals, as they have resources; and finally to Medicaid, if the individual is Medicaid eligible.

Determination of an individual's ability to pay will be made according to the regulations governing Medicaid eligibility as outlined in the South Carolina Department of Social Services (DSS) Medicaid Program Manual. The determination of an individual's ability to pay shall be the calculation of recurring income made by a county DSS office in accordance with an individual's application for Medicaid. This calculation shall be accepted without re-calculation by regional personnel. This amount of recurring income shall be used as the basis for billing the individual unless a specific exception is approved, as described in Section VII of this document.

IV. BILLINGS TO MEDICAID FOR ELIGIBLE INDIVIDUALS

The HHSFC shall be billed for each allowable day the individual is admitted to and resides in the regional center or the community based Habilitation Facility. "Allowable" days will be determined by the Medicaid regulations included in Section 214 of the HHSFC Medicaid Guidelines for ICF/MR's. Unallowable days shall not be billed.

V. BILLINGS AGAINST INDIVIDUAL'S ASSETS FOR MEDICAID ELIGIBLE INDIVIDUALS WITH RECURRING INCOME

Where an individual is eligible for Medicaid and has resources sufficient to contribute to the cost of residential services ("recurring income" - Section III), the individual shall be billed for each month of service. See Section VII for an explanation of factors that may affect this monthly billing. The amount of this billing generally will not be adjusted on the basis of allowable days.

VI. BILLINGS TO INDIVIDUALS NOT ELIGIBLE FOR MEDICAID

Individuals not eligible for Medicaid will be billed at a fixed monthly rate based on the current Medicaid per diem. The fixed rate will be adjusted whenever the current Medicaid per diem is adjusted. (See the discussion of "credit days" in Section VII.)

If an individual's assets are held by a parent, guardian, or other responsible party, the individual's billing shall be submitted to this party. If the department serves as trustee for an individual's funds, then the individual's bill shall be submitted to the department, to be paid through the Client Banking System.

If the individual has insurance which pays for residential care, then the bill shall be submitted to the insurance company. Billings to insurance companies shall be for the maximum allowable payment, up to the full cost of care.

VII. OTHER MATTERS

A. Partial Month Billings

When an individual is admitted to or discharged from a regional center or a community Habilitation Facility, the billings addressed in Sections IV, V, and VI shall be adjusted to reflect a partial month. This partial month does not apply to situations where individuals are on therapeutic leave, as allowed by the HHSFC.

B. Maximum Accumulation Level for Medicaid Eligibility

To prevent disruption of Medicaid eligibility, staff shall monitor individuals' accumulation of available resources to ensure that the accumulated resources do not exceed the amount allowed under Medicaid eligibility guidelines. The current amount is stated in Section 6.2 of the SCDMR Finance Manual.

The regional claims and collections officer should contact the respective program team when an individual's resources approach the maximum level. The program team should first determine if the individual has personal needs, such as clothing. If such needs exist, the purchases should be made, thus ensuring that individual funds are initially expended on personal needs. If, when the personal needs have been exhausted, the available resources are still above the allowable level, individual billing for residential services can be adjusted upward to the extent of any underbillings of full cost of care that have occurred in the past one year. Some situations that could create underbillings are granting credit days; granting waivers; allowing personal needs funds to be calculated based on net, rather than gross, wages. If after all personal needs have been exhausted and all prior underbillings have been

paid, the individual still has excess resources, the individual will become Medicaid ineligible for a period of time. During that period, full cost of care will be charged. The amount paid on this billing must be sufficient to bring client resources to, at most, the target asset level. (See Section 6.2 of the SCDMR Finance Manual for target asset levels.) Actual amounts to be paid will be determined by the claims and collections officer based on expected future accumulations of resources beyond Medicaid allowable resource limits.

C. Personal Needs Allowances

Each individual, whether Medicaid eligible or not, shall retain a portion of unearned income from Social Security, Supplemental Security Income, and other sources for personal needs ("personal needs allowance"). The amount of this personal needs allowance is published in the SCDMR Finance Manual in Section 6.2 ($30 per month as of July 1, 1990). This means that an individual's monthly resources up to the personal needs amount must not be applied to payments of residential or other departmental billings.

D. Individuals with Earned Income

If an individual, in any month, has any earned income from work activities or other sources, then that person may retain his or her total income (from both earned and unearned sources) up to the earned income allowance level. This level is published in the SCDMR Finance Manual in Section 6.2 ($100 per month as of July 1, 1990). This means that the individual's monthly income up to this level may not be applied to payments of residential or other departmental billings.

In calculating the funds to be retained by an individual, earned income after taxes and other withholdings shall be used. (NOTE: This is different from calculations done by DSS.) This will result in smaller billings, but is consistent with the intention of the policy, which is to allow each individual to realize monetary benefit from work efforts. As a result of using net wages to determine funds retention, income tax returns shall be filed for all individuals who have had income taxes withheld. The Facility Director will assign responsibility for the completion of individuals income tax returns. The amount of refunded taxes, up to the difference in billings created by using net wages, shall be billed to the individual after a tax refund is received.

E. Application of "Credit Days"

A "credit day" is a residential service day for which the individual is liable for all or a portion of that day's bill, but for which the individual is not charged. "Credit days" are used to encourage, or enable, an individual to spend time away from one of

DMR's regional centers or community Habilitation Facilities. Generally this means that the funds which are made available through the reduction of a monthly billing are used to cover the expenses incurred by a family to take care of the individual for a short time period.

A "credit day" is allowed when it is requested by the parent, guardian, or other responsible party who will be taking the individual home, and when it is determined by the claims and collections officer and the individual's interdisciplinary team to be necessary for the parent, guardian, or other responsible party to take care of the individual. Both the request and the determination of the claims and collections officer must be documented, and that documentation must be retained. All parents, guardians, or other responsible parties should be informed of the availability of credit days, and the procedure necessary to grant credit days at the time of admission.

When a credit day is allowed, the amount of the credit will be the pro rata share of the residential service billing for that individual for that month. The full billing shall be recorded on the Maintenance Accounts Receivable (MAR) system, and the amount of the credit shall be recorded also on MAR through an adjustment.

F. Receipt of Social Security Back Payments

When an individual receives a Social Security back payment, the funds will be used first to maximize the individual's personal needs allowance for the past 12 months.

See Exhibit 1 for an example of "maximizing the personal needs allowance." Second, if there is any outstanding care and maintenance receivable balance, the back payment will be applied to that balance. If, after correcting personal needs allowances and paying any back care and maintenance, the entire payment is not used, the individual shall retain the balance. If this balance gives the individual sufficient resources so that he/she may be determined Medicaid ineligible, these resources will be used in accordance with Section VII B.

G. The Department as Representative Payee

In cases where a parent or other responsible party is designated by the Social Security Administration (SSA) as a representative payee for an individual, it is the department's policy and the intent of SSA that all of the amount received be spent for the benefit of the individual. If a representative payee cannot demonstrate to the program team the proper use of these funds for the individual's benefit, the department shall request to be designated as representative payee.

H. Waiver of Fees by Regional Commissioner

Each regional commissioner is authorized to vary the amount of residential service fees if there is programmatic need for additional funds associated with a planned movement of an individual to another residential setting. If an adjustment to waive all or a portion of residential fees is required, a request for waiver with justification should be forwarded by the program team through the regional claims and collection officer to the regional commissioner. The waiver will be limited to a maximum of six (6) months. Upon approval by the regional commissioner, the waiver should be returned to the claims and collection officer, who in turn forwards a copy to the appropriate unit to be placed in the individual's personal files. The program plan supporting each waiver should be reviewed by the program team and the regional claims and collections officer every six (6) months the waiver is in effect to determine the continued need.

Deputy Commissioner for Fiscal Affairs (Originator)	Commissioner (Approved)

Please view the chart below:

MAXIMIZATION OF INDIVIDUAL'S PERSONAL NEEDS ALLOWANCE

MONTH	TYPES OF INCOME THIS MONTH	MAXIMUM PERSONAL NEEDS ALLOWANCE	PERSONAL NEEDS ALLOWANCE RETAINED	DIFFERENCE
12	Unearned only	$30	$30	$0
11	Unearned only	$30	$25	$5
10	Earned and Unearned	$100	$43	$57
09	Earned and Unearned	$100	$58	$42
08	Earned and Unearned	$100	$100	$0
07	Earned and Unearned	$100	$100	$0
06	Earned and Unearned	$100	$98	$2
05	Earned and Unearned	$100	$100	$0
04	Unearned	$30	$0	$30
03	Unearned	$30	$0	$30
02	Unearned	$30	$0	$30
01	Unearned	$30	$30	$0
Total				**$196**

Note: This is using the personal needs maximums in effect as of July 1, 1990.

In this case, from the back payment received, $196 would be given to the client to "maximize" his/her personal needs allowance.